CHAPTER 87
MEDICAID PROVIDER AUDITS

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The purpose of this chapter is to define steps which may be taken by the department of human services to ensure that provider payments for Medicaid services and supplies are made in accordance with provider manual and Medicaid rules.

441—87.1(249A) Definitions.

"Authorized representative" within the context of these rules means that person appointed to carry out audit procedures, including assigned auditors, fiscal agent consultants, or agents contracted for specific audits or audit procedures.

"Claim" means each record received by the department or its fiscal agent which tells the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible recipient.

"Clinical record" means a tangible and legible history which documents the criteria established for clinical records as set forth in rule 441—79.3(249A).

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

"Customary and prevailing" means (1) the most consistent charge by a Medicaid provider for a given service and (2) a fee within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Fiscal record" means a tangible and legible history which documents the criteria established for fiscal records as set forth in rule 441—79.3(249A).

"Generally accepted auditing procedures" means those procedures published in Standards for Audit of Governmental Organizations, Programs, Activities & Functions, 1972 edition, by the Comptroller General of the United States.

"Overpayment" means any payment or portion of a payment made to a provider which is incorrect according to the laws and rules applicable to the Medicaid program and which results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier which describes medical services performed or the supplies, drugs or equipment provided.

"Random sample" means a systematic (or every nth unit) sample for which each item in the universe has an equal probability of being selected.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items (claims), submitted by a specific provider for payment during a specific time period, from which a random sample will be drawn.

441—87.2(249A) Audit of clinical and fiscal records by the department.

87.2(1) Authorized representatives of the department shall have the right, upon proper identification, and using generally accepted auditing procedures, to review the clinical and fiscal records of the provider to determine whether:

a. The department has accurately paid claims for goods or services.

b. The provider has furnished the services to Medicaid recipients.

c. The provider has retained clinical and fiscal records which substantiate claims submitted for payment during the audit period.

87.2(2) Records generated and maintained by the department or its fiscal agent may be used by auditors and in all proceedings of the department.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.5.

441—87.3(249A) Who shall be audited. Any Medicaid provider may be audited at any time at the discretion of the department.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.5.

441—87.4(249A) Auditing procedures. The department will select the appropriate method of conducting an audit and will protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department.

87.4(1) Audit procedures may include, but are not limited to, the following:

a. Comparing clinical and fiscal records with each claim.

b. Interviewing recipients of services, and employees of providers.

c. Examining third-party payment records.

d. Comparing Medicaid charges with private patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee. Records of privately paying patients will be requested by subpoena.

87.4(2) Use of statistical sampling techniques. The department's procedures for auditing Medicaid providers may include the use of random sampling and extrapolation. When this procedure is used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level. Findings of the sample will be extrapolated to the universe for the audit period.

a. The audit findings generated through the audit procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. When the department's audit findings have been generated through the use of sampling and extrapolation, and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit of the universe of provider records used by the department in the drawing of the department's sample. Any such audit must:

(1) Be arranged and paid for by the provider,

(2) Be conducted by a certified, public accountant,

(3) Demonstrate that bills and records not reviewed in the department's sample were in compliance with program regulations, and

(4) Be submitted to the department with all supporting documentation.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.5.

441—87.5(249A) Actions based on audit findings.

87.5(1) The department shall report the results of an audit of provider records to concerned parties consistent with the provisions of 441—Chapters 9 and 79 and Iowa Code section 17A.2.

87.5(2) When an overpayment is found, the department may proceed with one or more of the following:

a. Request repayment in writing.

b. Impose sanctions provided for in rule 441—79.2(249A).

c. Investigate and refer to an agency empowered to prosecute as provided for in Iowa Code sections 249A.4 and 249A.5.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.5.

441—87.6(249A) Appeal by provider of care. Providers may appeal decisions of the department according to rules in 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

[Filed 12/13/85, Notice 8/14/85—published 1/1/86, effective 3/1/86]*
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

*Effective date of Ch 87 delayed 70 days by the Administrative Rules Review Committee.